DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. BUILDING _____ B. WING _____	C 09/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

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F 000	INITIAL COMMENTS Complaint investigation #39230, #39389, #39424, #39585, and #39651 were completed at Cumberland Health and Rehabilitation Center on 8/22/16-9/21/16. No deficiencies were cited related to complaint investigation #39585 and #395651. Deficiencies were cited related to complaint investigation #39230, #39389, and #39424, under 42 CFR Part 483 Requirements for Long Term Care Facilities.	F 000	The facility will have documented evidence that all alleged allegations of abuse, neglect, mistreatment, or misappropriations are thoroughly investigated and will prevent further potentionallegations while the investigation is in progress. Corrective Action: 1. Administratior immediately re-educated all Department Heads regarding:	11/4/16
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the	F 225	a. Company policies and procedures regarding allegations of Abuse, neglect, mistreatment, misappropriation, patient occurences, and mandatory reportable incidents. b. The components of a thorough investigation for abuse, neglect, mistreatment, misappropriation, patient grievances/occurrences, and mandatory reportable incidents. c. Methods to insure prevention of further potential allegations while the investigation is in progress. Resident #1 was assessed by both Psych NP and General NP. Resident #2 has been discharged from this facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ted M. Beasley | TITLE: Administration | (X6) DATE: 10/31/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, review of a facility investigation, and interview, the facility failed to follow their policy for occurrence investigations and failed to complete a thorough investigation for allegations of abuse for 2 residents (#1, #3) of 8 residents reviewed for abuse. The findings included: Review of facility policy, Abuse, dated 6/14 revealed, "...The policy provides the procedure and practice in the event of an incident of actual or suspected abuse. The Administrator must lead the facility and oversee the investigation of all incidents of abuse...The important thing to remember is that all reports are treated in the same fashion. The first and most important step is ensuring the safety of the patients. The next step is to conduct a THOROUGH investigation that is well documented...Investigation Checklist...Is there a detailed accounting of the incident...or injury documented in the nurses notes? Social services notes should also document any 'patient to patient' altercation...Was	F 225	Resident #3 was assessed immediately by nursing staff and found to have no physical s/sx of injury. Patient also seen by both Psych NP (8/8) and Psychologist (8/9) and found to have no psychological effects noted from incident. The responsible party for the resident was notified as well. 3. Administrator or designee will re-educate 100% of all stafff of company policy and procedures regarding abuse, neglect, mistreatment,misappropriation, patient occurence/ grievances,including notification of the Administrator, of all allegations, the documentation required and acceptabletime frame for mandatory state reportable events by 11/4/2016. Administrator of designee will re-educate 100% of all licensed nursing staff on proper completion of nurse events notes per policy for any allegations of abuse, neglect, mistreatment, misappropriation, patient occurences and reportable incidents 4. Administrator or designee will audit 100% of all allegations of abuse, neglect, mistreatment, misappropriation, patient occurences and reportable incidents to assure investigation and documentation are completed,including the post occurence analysis and its attachment to the occurence report,as per company policy and procedure for 8 weeks or until 100% compliance is achieved for 4 consecutive weeks. All findings of the 8 week audit will be monitored and reported to the Regional Director of Operations. Any findings will be addressed immediately with staff responsible per facility's policy by the Administrator.	

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F 225	Continued From page 2 the Nurse Event Note completed with no blanks and follow up done for 72 hours or until resolved?...Were preventative measures taken to prevent similar incidents...or injuries from occurring again?..." Review of facility policy, Occurrences, Patient, dated 9/14 revealed, "...An occurrence is any happening, which is not consistent with the routine...care of a particular patient...It might be an...unusual happening, or situation...Upon discovery of a patient occurrence, the charge nurse must complete the Nurse's Event Note. The original is to be filed in the patient's chart...All areas of the note must be completed...The investigation area...must also be completed...Nursing Administration should also complete the Post Occurrence Analysis Report and attach report to the Occurrence Investigation...An appropriate intervention must be implemented by the charge nurse immediately to prevent recurrence. Observe the patient for the next 72 hours...Document observations each shift emphasizing pertinent problems that might occur from the occurrence...it is important to get accurate information in a thorough investigation that will help uncover the cause of the occurrence, which in turn will hopefully prevent similar occurrences from happening...An injury (including bruises...) that was not observed by any person...is considered an injury of unknown origin and requires a thorough investigation...The investigation must include all personnel who have had contact with the patient during the past 48 hours, or more if indicated..." Medical record review revealed Resident #1 was admitted to the facility on 5/13/16 with diagnoses including Hypertension, Bipolar, Left Foot Drop,	F 225	All results of the audits will be included in the facility's Quarterly QA/QI Meetings which are attended by all Facility Leadership and Medical Director. Per company policy, the findings will be reviewed for pertinent data, identify areas that may need additional attention, and determine specific goals to acheive if necessary. The facility Administrator will be responsible for overseeing the outcome of the findings and the QA/QI Process.	

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F 225	Continued From page 3 Brown-Sequard Syndrome, Hemiparaplegia Syndrome and Drug/Chemical Induced Diabetes Mellitus. Review of a facility investigation dated 8/5/16 revealed Resident #1 claimed an allegation of abuse by a female night shift staff member who grabbed her arm and left a bruise in the early morning of 8/2/16.The resident was unable to name the alleged perpatrator. The facility investigation included statements from 1 male nurse, Certified Nurse Aide (CNA) #2, Resident #1's roommate, and a resident across the hall from the resident; a statement from the resident, and a skin assessment dated 8/5/16 indicating a fading bruise to the resident's right upper forearm. Review of a Daily Assignment Sheet dated 8/2/16 revealed the male nurse was not working on 8/2/16 and 2 female nurses worked the 11 PM - 7 AM shift that night. Continued review revealed 4 other CNA's and CNA #2 worked the night shift. Medical record review revealed no Nurse's Event Note in the clinical notes, no Post Occurrence Analysis Report completed by nursing administration, no detailed accounting of the incident documented in the nurse notes, and no 72 hour documentation of observations of the resident after the alleged occurrence in the clinical notes. Continued review revealed a nursing note dated 8/5/16 regarding restorative range of motion and the next nursing note was dated 8/17/16. There was no documentation of a Social Service follow up visit. Interview with the Director of Nursing (DON) on 8/31/16 at 1:30 PM, in the Conference Room	F 225		

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F 225	Continued From page 4 revealed she had no knowledge of a bruise to Resident #1 until today when the Assistant Director of Nursing (ADON) mentioned it to her. The DON confirmed there was no Nurse's Event Note in the clinical notes for Resident #1; no Post Occurrence Analysis Report; no 72 hour documentation of observations of the resident after knowledge of the alleged abuse occurred and no follow up visit or notes from Social Services. Continued interview revealed the DON stated she would have completed head to toe skin assessments on all cognitively impaired residents in the care of CNA #2, and interviewed all cognitively intact residents. The DON stated she would have notified Psych Services and Social Services to visit Resident #1. Continued interview with the DON confirmed the facility failed to fully investigate the allegation of abuse and a bruise of unknown origin for Resident #1. Interview with the Administrator on 9/1/16 at 1:00 PM, in the Conference Room confirmed the facility failed to complete a thorough investigation for allegations of abuse for Resident #1. Medical record review revealed Resident #3 was admitted to the facility on 7/22/16 with diagnoses of Nontraumatic Intracerebral Hemorrhage, Hypertension, Asthma, Anxiety, Dysphagia, Altered Mental Status, Diabetes Type II, and Difficulty in Walking. Review of a facility investigation dated 8/2/16 revealed an incomplete Nurse's Event Note dated 8/1/16, hand written statements from CNA #1, and Licensed Practical Nurse (LPN #4), regarding a witnessed physical altercation between Resident #2 and Resident #3. Continued review of LPN #4's statement revealed, "...The techs	F 225		

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F 225	Continued From page 5 noticed [Resident #2] standing at the head of the bed of [Resident #3]...I instructed everyone in the room to back off of [Resident #2]...Once patient [Resident #2] walked out of the room 3 staff members tried to prevent [Resident #2] from falling...while other staff was instructed to stay with [Resident #3]...Continued review revealed no names or statements from the 3 staff members present, or the staff member who stayed with Resident #3 who had knowledge of the resident to resident altercation as reported by LPN #4 were present in the facility investigation. Medical record review revealed no Post Analysis Occurrence Report and no follow up with Social Services. Interview with the DON on 8/31/16 at 1:30 PM, in the Conference Room confirmed the facility investigation for Resident #3 was incomplete and not thoroughly investigated. The DON confirmed the facility failed to thoroughly investigate the resident to resident altercation for Resident #3.	F 225		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280	Requirement: A comprehensive care plan will be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending phyisician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent predictable, the participation of the resident, the resident's family or the resident's legal representative, and periodicallly reviewed and revised by a team of qualified persons after each assessment.	11/4/16 TB/RC

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F 280	Continued From page 6 disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to revise the comprehensive care plan for 2 residents (#1, #2) of 8 resident's reviewed. The findings included: Medical record review revealed Resident #1 was admitted to the facility on 5/13/16 with diagnoses including Hypertension, Bipolar, Left Foot Drop, Brown-Sequard Syndrome, Hemiparaplegia Syndrome and Drug/Chemical Induced Diabetes Mellitus. Medical record review of an Admission Minimum Data Set (MDS) dated 5/20/16 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15/15 indicating she was cognitively intact. The resident had no behaviors and used a wheelchair for locomotion. Medical record review of Clinical Notes dated 6/27/16 at 1:25 PM revealed Resident #1 was observed in a male resident's room with his hand close to the side of her breast. The male resident's roommate "...stated that he observed them kissing..." Continued review revealed a	F 280	Corrective Action: 1. The Care plan for Resident #1 was corrected and updated by the MDS Nurse immediately to assure it accurately reflects the patient's needs. 2. The DON or designee will immediately review 100% of all care plans for those known to have behavior issues identified on the Behavior Monitoring Log which is maintained by the Social Worker to assure they are accurate and appropriate interventions are in place. 3. MDS Nurse and all licensed staff will be re-educated on care plan accuracy and revising as needed to maintain accuracy by the DON or deesignee by 11/4/2016. 4. The DON or designee will randomly audit 4 care plans a week for 2 weeks, 2 care plans a week for 2 weeks then 1 care plan a week for 2 weeks, or until 100% compliance is achieved for 4 consecutive weeks, to assure care plan and intervention accuracy Any findings will be addressed immediately with staff responsible per facility's policy by the Administrator. All results of the audits will be included in the facility's Quarterly QA/QI Meetings which are attended by all Facility Leadership and Medical Director. Per company policy, the findings will be reviewed for pertinent data, identify opportunities for improvement and determine specific goals to achieve if necessary. The facility Administrator will be responsible for overseeing the outcome of the findings and the QA/QI Process.	

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F 280	Continued From page 7 Clinical note dated 7/22/16 at 4:57 PM revealed "...noted by CNA [certified nurse aide] with male pt. [patient] outside during designated smoke break touching him in genital area on top of clothes and attempting to kiss him on mouth. CNA asked her to stop and she refused, asked by CNA again to stop and she did not..." Clinical note dated 8/22/16 at 8:19 PM revealed, "...informed that resident has been displaying behaviors, such as demanding staff to provide care for her at the minute that it is requested. When she doesn't get staff's attention right away, she proceeds to ram her wheelchair into the walls at the nurses's station and yell out 'I want it now.'..." Medical record review of the comphrensive care plan for Resident #1 revealed no problem of sexual or verbal behaviors with interventions was present. Interview with the Director of Nursing (DON) on 8/31/16 at 1:30 PM, in the Conference Room confirmed Resident #1's care plan was not revised to include behaviors. Continued interview with the DON confirmed the facility failed to revise the comprehensive care plan related to sexual and verbal behaviors for Resident #1. Medical record review revealed Resident #2 was admitted to the facility on 6/1/16 with diagnoses including Altered Mental Status, Dementia with Lewy Bodies and Behaviors, Parkinson's Disease, Unspecified Mood Disorder, Insomnia, Hypertension, Cognitive Communication Deficit, and Cardiac Arrhythmia. The resident was discharged on 8/1/16. Medical record review of an Admission MDS dated 6/8/16 revealed the resident scored a 5/15	F 280		

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F 280	Continued From page 8 on the BIMS indicating Resident #2 was severely cognitively impaired. Continued review revealed the resident had physical and verbal behavioral symptoms directed toward others, for 1-3 days of the 7 day look back period. The resident significantly intruded on the privacy of others and was significantly disruptive to the care and living environment. He rejected care and had behaviors of wandering 1-3 days of the 7 day look back period which significantly intruded on the privacy of other residents. Continued review revealed the resident was ambulatory and required supervision of 1 person. Medical record review of Clinical Notes dated 6/2/16 at 12:48 AM revealed, "...patient noted to [be] completely naked standing in front of sleeping roommate..." Continued medical record review of Clinical notes dated 6/2/16 at 9:04 AM revealed, "...pacing, rummaging through other residents belonging especially foods...disrobing in public, wandering, seeking exits...easily agitated high anxiety...resistant at times from redirection..." Further medical record review of the Clinical Notes dated 6/2/16 at 10:31 PM revealed "...Resident wandering into rooms and was asked to come out. Upon guiding resident out of the room, resident tried to hit at me by balling fist and flexing toward me...Resident can become combative easily when being redirected..." Medical record review of Clinical notes dated 6/3/16 at 10:50 PM revealed "...resident noted in another residents room sitting on bed eating food from her room..." and at 11:04 PM "...wandering in several residents room, residents getting upset...Resident noted pulling at furniture and the railing in the hallway. Resident becomes a little agitated when attempting to redirect..." Continued medical record review	F 280		

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F 280	Continued From page 9 dated 6/5/16 at 5:55 PM revealed, "...Resident is wandering in hallway nude; numerous attempt to put clothes on resident but resident resistive. Resident took meds and spit them out saying I am not taking any medication to hell with you...Helping resident only led to agatation/anxiety. Resident went down to hallway door trying to get out...swinging out at staff members... resident returned to same behaviors..." Medical record review of Clinical notes dated 7/10/16 at 12:09 AM revealed, "...Patient found in his room pulling his roommate by the feet towards the floor...several redirection techniques with no effectiveness...Resident then began to take off his pants and get into bed with roommate..." On 7/27/16 at 10:09 PM clinical notes documented "...Resident going in and out of other patient's rooms closing doors behind him...resident will not leave the room unless assisted by more than one staff member...During supper resident pulled out penis and urinated on the floor. One hour later resident noted to be urinating on nurses med cart and aiming at another residents head..." 7/28/16 at 5:51 PM clinical notes documented "...disrobing in public, grabbing items from other resident's...grabbing water pitcher off cart...urinating in hallway in corners...approached female table and started pulling off tablecloth...then he proceeded around the table and pinched a female resident upper right arm...becomes aggressive pulls away aggressive stance acts like he's going to hit staff when he was separated from female resident..." On 7/31/16 at 6:27 PM clinical notes revealed "...Continues disrobing in public, smearing stool on bed and chair...wandering...continues to urinate in hallway, standing up in center of bed today after approximately 20 minutes came down...reassurance not effective..."	F 280		

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F 280	Continued From page 10 Medical record review of a comprehensive care plan dated 6/14/16 revealed a problem of verbal behavioral symptoms directed toward others. Openly expresses anger with others. Interventions included "...Encourage [resident] to verbalize feelings in an appropriate manner and provide realistic feedback...talk with family...to identify potential sources/reasons..." Continued reveiw revealed no further interventions were present on the care plan to address the resident's specific verbal behaviors and anger. Medical record review of the comprehensive care plan dated 6/14/16 revealed a problem of noncompliant with care and presents with acting out behaviors related to Lewy body dementia, and intermittent confusion. Interventions included to offer alternate choices when refusal of care occurs; staff to attempt to redirect resident verbally during episodes of acting out behaviors. Further review revealed no further specific interventions were present on the care plan when redirection of the resident was unsuccessul during multiple episodes of acting out behaviors. Interview with the MDS Coordinator on 8/31/16 at 11:30 AM in the MDS office confirmed the comprehensive care plan did not address Resident #2's behaviors with specific interventions. Interview with the Director of Nursing (DON) on 8/31/16 at 1:30 PM, in the Conference Room confirmed Resident #2's comprehensive care plan had not been updated to reflect his specific behaviors. The DON confirmed the interventions were not specific and were not appropriate. Interview with the DON confirmed the facility	F 280		

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F 280	Continued From page 11 failed to revise the comprehensive care plan relating to behaviors for Resident #2.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow the comprehensive care plan for 2 residents (#1, #2) residents of 8 residents reviewed. The findings included: Medical record review revealed Resident #1 was admitted to the facility on 5/13/16 with diagnoses including Hypertension, Bipolar, Left Foot Drop, Brown-Sequard Syndrome, Hemiparaplegia Syndrome and Drug/Chemical Induced Diabetes Mellitus. Medical record review of the comprehensive care plan dated 5/26/16 revealed "...[Resident #1] is receiving antidepressant drugs on a regular basis..." Interventions included, "...Conduct 1 on 1 visit with [Resident #1] to discuss current status and adjustment to lifestyle changes..." Social Service (SS) was to visit "1 Time Weekly Starting 05/26/2016." Review of the Clinical Notes revealed a visit from	F 282	Requirement: The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. Corrective Action: 1. DON or designee will perform audit of identified resident #1 to assure care plan interventions are in place and are documented & completed appropriately. Resident #2 has been discharged from facility. 2. DON or designee will perform 100% audit of all residents with behaviors to assure care plan interventions are in place and are documented & completed appropriately. 3. All licensed staff, including Nursing Leadership and MDS Nurse will be re-educated by DON or designee regarding providing or arranging services by qualified persons in accordance with each resident's written plan of care and documenting accordingly. 4. The DON or designee will randomly audit 4 resident's care plans a week for 2 weeks, 2 care plans a week for 2 weeks then 1 care plan a week for 2 weeks, or until 100% compliance is achieved for 4 consecutive weeks, to assure care plan interventions are in place and are documented, followed & completed appropriately. Any findings will be addressed immediately with staff responsible per facility's policy by the Administrator.	11/4/16

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	445262	A. BUILDING _____ B. WING _____	C 09/21/2016

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F 282	Continued From page 12 SS on 5/13/16 and 8/22/16. Continued review revealed no other documentation was noted from SS in the resident's medical record. Interview with the MDS Coordinator on 8/31/16 at 11:30 AM, in the MDS office confirmed SS did not visit with Resident #1 weekly as indicated on the care plan. The MDS Coordinator confirmed the facility failed to follow the comprehensive care plan. Medical record review revealed Resident #2 was admitted to the facility on 6/1/16 with diagnoses including Altered Mental Status, Dementia with Lewy Bodies and Behaviors, Parkinson's Disease, Unspecified Mood Disorder, Insomnia, Hypertension, Cognitive Communication Deficit, and Cardiac Arrhythmia. The resident was discharged on 8/1/16. Medical record review of the comprehensive care plan revealed a problem of wandering. Interventions included, "...Check location/whereabouts of [resident] every 30 minutes on each shift..." Further review revealed no documentation of every 30 minute checks per shift were present in the medical record for Resident #2. Interview with the DON on 8/31/16 at 1:30 PM, in the Conference Room confirmed the facility failed to check on the whereabouts of Resident #2 every 30 minutes.The DON confirmed the facility failed to follow the comprehensive care plan.	F 282	All results of the audits will be included in the facility's Quarterly QA/QI Meetings which are attended by all Facility Leadership and Medical Director. Per company policy, the findings will be reviewed for pertinent data, identify areas that may need additional attention, and determine specific goals to acheive if necessary. The facility Administrator will be responsible for overseeing the outcome of the findings and the QA/QI Process.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323	Requirement: The facility will ensure that the resident environment remains free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents.	11/4/16

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F 323	Continued From page 13 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, review of a facility investigation, and interview, the facility failed to prevent a resident to resident altercation for 1 resident (#3) of 8 residents reviewed for abuse. The findings included: Review of facility policy, Resident Rights, dated 9/14 revealed, "...Listing of Resident Rights...To be free from mental and physical abuse..." Review of facility policy, Abuse, dated 6/14 revealed, "...This facility practices the concept of 'zero tolerance' for patient abuse. Nurse management must strive to ensure that the patients are free from verbal, sexual, physical and mental abuse...Abuse may involve patients...all reports are treated in the same fashion. The first and most important step is ensuring the safety of the patients...Policy...To operate the facility where all patients are free from verbal, sexual, physical and mental abuse...Facility will identify patients whose personal history renders them at risk for abusing other patients. The facility will assess, develop intervention strategies, monitor for changes and reevaluate interventions as needed..."	F 323	Corrective Action: 1. Resident #3 identified during survey has been discharged from the facility. 2. The DON or designee will perform a 100% audit of all current resident's with documented behaviors identified in our Behavior Monitor Log that is maintained by Social Services, that could potentially result in a resident to resident altercation to assure adequate interventions are in place for prevention and that the needs of the resident requiring additional supervision are met. Any negative findings will be immediatelycorrected and appropriate interventions put into place. 3. All licensed staff will be re-educated by DON or designee on assessing and implementing adequate interventions to meet the needs of residents requiring supervision and to prevent resident to resident altercations by 11/4/16. 4. The DON or designee will randomly audit 4 care plans a week for 2 weeks, 2 care plans a week for 2 weeks then 1 care plan a week for 2 weeks, or until 100% compliance is achieved for 4 consecutive weeks, to assure care plan interventions are in place and are documented & completed/in place appropriately. Any findings will be addressed immediately with staff responsible per facility's policy by the Administrator. All results of the audits will be included in the facility's Quarterly QA/QI Meetings which are attended by all Facility Leadership and Medical Director. Per company policy, the findings will be reviewed for pertinent data, identify areas that may need additional attention, and determine specific goals to acheive if necessary.	11/4/16

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F 323	Continued From page 14 Medical record review revealed Resident #2 was admitted to the facility on 6/1/16 with diagnoses including Altered Mental Status, Dementia with Lewy Bodies and Behaviors, Parkinson's Disease, Unspecified Mood Disorder, Insomnia, Hypertension, Cognitive Communication Deficit, and Cardiac Arrhythmia. The resident was discharged on 8/1/16. Medical record review of an Admission Minimum Data Set (MDS) dated 6/8/16 revealed the resident scored a 5/15 on the Brief Interview for Mental Status (BIMS) indicating Resident #2 was severely cognitively impaired. The resident had physical and verbal behavioral symptoms directed toward others, for 1-3 days of the 7 day look back period. The resident significantly intruded on the privacy of others and was significantly disruptive to the care and living environment. He rejected care and had behaviors of wandering 1-3 days of the 7 day look back period. Continued review revealed the resident was ambulatory and required supervision of 1 person. Medical record review of Clinical Notes dated 6/2/16 at 12:48 AM revealed, "...patient noted to be completely naked standing in front of sleeping roommate..." 6/2/16 at 9:04 AM notes revealed, "...pacing, rummaging through other resident belongings especially foods...disrobing in public, wandering, seeking exits...easily agitated high anxiety...resistant at times from redirection..." 6/2/16 at 10:31 PM documented "...Resident wandering into rooms and was asked to come out. Upon guiding resident out of the room, resident tried to hit @ [at] me by balling fist and flexing toward me...Resident can become combative easily when being redirected..." Continued review on 6/5/16 at 5:55 PM revealed,	F 323	The facility Administrator will be responsible for overseeing the outcome of the findings and the QA/QI Process.	

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F 323	Continued From page 15 "...Resident is wandering in hallway nude; numerous attempts to put clothes on resident but resident resistive...swinging out at staff members...7/10/16 at 12:09 AM clinical notes documented, "...Patient found in his room pulling his roommate by the feet towards the floor...several redirection techniques with no effectiveness...Resident then began to take off his pants and get into bed with roommate..." 7/28/16 at 5:51 PM clinical notes documented "...disrobing in public, grabbing items from other resident's...grabbing water pitcher off cart...urinating in hallway in corners...approached female table and started pulling off tablecloth...then he proceeded around the table and pinched a female resident's upper right arm...becomes aggressive pulls away aggressive stance acts like he's going to hit staff when he was separated from female resident..." Review of clinical notes dated 8/1/16 at 12:14 AM documented, "...Resident...in the roommates area holding the roommates [Resident #3] right wrist tightly with his left hand. This writer and another staff member tried to remove the patients hand from his roommates arm and patient reached down and grabbed the roommates gown with right hand at the area of roommates neck. After several unsuccessful attempts to detach the roommates arm from patients hand...patient let the roommate go and walked out of the room..." Medical record review of the comprehensive care plan dated 6/14/16 revealed a problem of wandering. Interventions included, "...Check location/whereabouts of [Resident #2] every 30 minutes on each shift..." Medical record review revealed 1:1 hourly monitoring of Resident #2 on 6/27/16 from 1:00	F 323		

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F 323	Continued From page 16 PM-6/28/16 at 6:00 AM; 6/28/16 from 7:00 AM-3:00 PM, and from 11:00 PM to 6/29/16 at 6:00 AM; 6/29/16 at 7:00 AM-11:00 PM; 6/30/16 from 7:00 AM- 3:00 PM; 7/28/16 from 4:00 PM-6:00 PM; 7/29/16 from 7:00 AM-1:00 PM, and 3:00 PM-7/30/16 at 6:00 AM; 7/30/16 at 7:00 AM-3:00 PM; and 7/31/16 from 7:00 AM-3:00 PM. Interview with Licensed Practical Nurse (LPN #2) on 8/23/16 at 11:11 AM, in the Conference Room confirmed the wandering and behaviors of Resident #2 and his need for constant observation and redirection. When asked if the facility was able to meet the needs of the resident with adequate supervision, the LPN stated, "No I do not. Our staff is already lacking and we needed to watch him all of the time." Medical record review revealed Resident #3 was admitted to the facility on 7/22/16 with diagnoses of Nontraumatic Intracerebral Hemorrhage, Hypertension, Asthma, Anxiety, Dysphagia, Altered Mental Status, Diabetes Type II, and Difficulty in Walking. Medical record review of an Admission MDS dated 7/29/16 revealed a BIMS score of 5/15 indicating the resident was severely cognitively impaired. Resident #3 required extensive assistance of 2 people for transfers and extensive assistance of 1 person for locomotion. He had bilateral lower extremity impairments and used a wheelchair at all times. Review of a handwritten statement in a facility investigation by Certified Nurse Aide (CNA #1) dated 8/1/16 revealed, "...On 7/30/16 I observed [Resident #2] a resident in room 502A walked toward the resident in room 502B bed and	F 323		

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F 323	Continued From page 17 grabbed his hand very tightly...I have seen him many times trying to get in the bed of [Resident #3] 502B resident his roommate. Many times I have separated him from his room [mate] trying to grab him..." Medical record review of Clinical Notes dated 8/1/16 at 1:24 AM revealed, "Resident in bed 502B noted to be laying in bed with arm being held tightly by roommate 502A...attempted multiple times to remove arm from roommates hands but was not successful. 502A grabbed 502B by the gown in [front] by neck tightly. Staff able to lure the patient away from 502A...Patient in bed 502B appeared frightened..." Interview with the DON on 8/31/16 at 1:30 PM, in the Conference Room confirmed the facility failed to follow the comprehensive care plan and check on the whereabouts of Resident #2 every 30 minutes thus resulting in a resident to resident altercation with Resident #3. The DON confirmed the facility failed to protect Resident #3 from the physical behaviors of Resident #2.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, manufacturer's specifications review, and interview, the facility failed to administer the correct medication per the physician's order, and	F 332	Requirement: The facility will ensure that it is free of medication error rates of five percent or greater. Corrective Action: 1. Nurse #1 administering inhaled medication on resident #8 was immediately re-educated by DON on manufacturer's specification regarding administration of Symbicort-specifically the wait time inbetween puffs. Nurse #1 administering Calcium Carbonate to resident #8 was immediately re-educated by DON on correct medication administration as per MD order 2. All residents with orders for Calcium Carbonate were audited immediately on 8/29/16 to assure that the correct medication was being administered.	11/4/16

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F 332	Continued From page 18 failed to correctly administer an inhalation medication per the manufacturer's specifications for 1 resident (#8) of 4 residents observed during a medication pass of 25 medications administered, resulting in a medication error rate of 8%. The findings included: Observation of Licensed Practical Nurse (LPN #1) on 8/29/16 at 9:05 AM, in room 303A revealed the LPN administered Calcium 600 milligrams (mg) plus D3 (Vitamin) 200 mg 1 tablet by mouth. Continued observation revealed the LPN administered Symbicort 160-4.5 mg inhalation medication 2 puffs consecutively one right after another to Resident #8. Medical record review of of a Physician's order dated 8/8/16 revealed an order for Calcium Carbonate 600 mg po (by mouth) daily. Continued review revealed an order for Symbicort 160-4.5 mcg (micrograms) 2 puffs inhalation twice daily. Review of manufacturer's specifications for Symbicort with a revision date of 10/15 revealed, "...If your prescribed dose is 2 puffs, wait at least one minute between them..." Interview with LPN #1 on 8/29/16 at 10:40 AM, in the Conference Room confirmed she administered Calcium 600 mg with D3 200 mg instead of Calcium Carbonate 600 mg as prescribed by the Physician to Resident #8. Continued interview confirmed the LPN failed to wait at least one minute between each puff of Symbicort administered to Resident #8.	F 332	3..All nurses will be re-educated by DON or designee on policy and procedure regarding correctly administering medications including inhalers by 11/4/16. All nurses will be assessed for competency in their skill of administering inhaled medications as per manufacture's specifictions by 11/4/16. 4. DON or designee will perform random medication administration audits 3 times a week for 2 weeks, 2 times a week for 2 weeks, 1 time a week for 2 weeks or until 100% compliance is achieved for 3 consecutive weeks. Any findings will be addressed immediately with staff responsible per facility's policy by the Administrator. All results of the audits will be included in the facility's Quarterly QA/QI Meetings which are attended by all Facility Leadership and Medical Director. Per company policy, the findings will be reviewed for pertinent data, identify areas that may need additional attention, and determine specific goals to acheive if necessary. The facility Administrator will be responsible for overseeing the outcome of the findings and the QA/QI Process.	

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F 332	Continued From page 19 Interview with the Director of Nursing (DON) on 8/29/16 at 11:00 AM, in the Conference Room confirmed there was no Calcium Carbonate 600 mg in stock in the facility at the present time. Continued interview confirmed Symbicort administration instructed users to wait at least one minute between each puff. Continued interview with the DON confirmed the facility failed to achieve a less than 5% medication error rate during the observation of med pass in the facility.	F 332		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	Requirement: The facililty will employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled druges in sufficient detail to enable an accurate reconcilliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility will be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permits only authorized personnel to have access to the keys. The facility will provide separately locked, permanently affixed compartments for storage of conrolled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	11/4/16

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F 431	Continued From page 20 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation, and interview, the facility failed to properly store home medications for 1 resident (#11) of 1 resident reviewed and failed to accurately reconcile controlled medications for 2 residents #12, #13) on 1 medication cart of 4 medication carts reviewed. The findings included: Review of facility policy, Medication Disposition Policy and Procedure, undated revealed, "...This policy will address the proper procedure for the disposition of...noncontrolled...medications...The medication should be...placed in the pre-disposal storage container located in the controlled access medication room..." Review of facility policy, Medication Storage, undated revealed, "Organization in the med room is a must. Routine checks must be accomplished to ensure that...medications are discarded...Medications must be properly stored in medication rooms..." Observation on 8/22/16 at 7:50 PM, in the Medication Room with the Assistant Director of	F 431	Corrective Action: 1. The medications identified for patient #11 were immediately stored and secured per company policy and procedure.The narcotic counts for residents #12 and #13 were immediately corrected. 2. Narcotic counts of all carts were immediately audited by Nursing Leadership to assure counts were accurate. 3. All licensed nurses will be re-educated by the DON or designee on the following by 11/4/16: a. Proper, secure storage of medications, both controlled and non-controlled according to company policy and procedure. b. Correct documentation and count process of narcotic, Schedule II drugs according to company policy and procedure. 4. DON or designee will audit the following: a. Medication room will be audited 3 times a week for 2 weeks, 2 times a week for 2 weeks and weekly for 2 weeks or until 100% compliant with medication storage. b. Individual cart narcotic count records will be audited randomly 3 times a week for 2 weeks, 2 times a week for 2 weeks and 1 time a week for 2 weeks or until 100% compliance is achieved for 3 consecutive weeks. Any findings will be addressed immediately with staff responsible per facility's policy by the Administrator.	11/4/16

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F 431	Continued From page 21 Nursing (ADON) revealed a clear plastic bag with bottles of the following medications inside the bag sitting in the sink on top of an empty medication box in the medication room. The medications belonged to Resident #11. Junevia 100 mg (milligram) tablets (Diabetic medication) Metformin 1000 mg tablets (Diabetic medication) Valsartan 320 mg tablets (Blood pressure medication) Dorzolamide/Timolol 0.68% plus 2.23% eye drops 1 vial (Glaucoma medication) Brimonidine Ophthalmic eye drops 2 vials (Glaucoma medication) Levothyroxine 88 mcg (micrograms) tablets (Thyroid medication) Atenolol-HCTZ 50/25 mg tablets (Blood pressure medication) Myrbetriq ER 25 mg tablets (Overactive bladder medication) Glimepiride 1 mg tablets (Diabetic medication) Interview with the ADON on 8/22/16 at 7:50 PM, in the Medication Room confirmed the above medications were Resident #11's home medications. The ADON stated, "The nurses were supposed to log them in and lock them up in the safe until she is discharged. I guess they didn't have time to log them yet." When asked if medications were to be stored in the sink in the medication room the ADON stated, "No, they are not." The ADON confirmed the facility failed to properly store Resident #11's home medications. Review of facility policy, Controlled Medications, dated 7/14 revealed, "...The management of controlled medications is a matter of utmost importance. Irregularities of the drug count	F 431	All results of the audits will be included in the facility's Quarterly QA/QI Meetings which are attended by all Facility Leadership and Medical Director. Per company policy, the findings will be reviewed for pertinent data, identify areas that may need additional attention, and determine specific goals to acheive if necessary. The facility Administrator will be responsible for overseeing the outcome of the findings and the QA/QI Process.	

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	445262	A. BUILDING _____ B. WING _____	C 09/21/2016

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F 431	Continued From page 22 cannot be tolerated...The count of each controlled substance must be audited at every shift change...If the count is incorrect, the DON must be notified immediately...Whenever an irregularity is noted, the nurse on duty at the time of the audit is accountable for the count..." Observation on 8/29/16 at 11:30 AM at the Nurse Station of medication cart #3 with the Director of Nursing (DON) and Licensed Practical Nurse (LPN #2) during a random narcotic count revealed a Controlled Drug Receipt/Record/Disposition Form for Resident #12 for Hydrocodone/APAP (Narcotic pain medication) 5-325 mg tablets. The last dose was documented as 1 tablet administered on 8/29/16 at 12:00 PM by LPN #2 and the remaining count was 6 tablets. Observation of the medication card for Hydrocodone/APAP 5-325 mg revealed 5 tablets on the card. Continued observation revealed a Controlled Drug Receipt/Record/Disposition Form for Resident #13 for Hydrocodone/APAP 5-325 mg tablets. The last dose was documented as 1 tablet administered on 8/29/16 at 12:00 PM by LPN #2 and the remaining count was 21 tablets. Observation of the medication card for Hydrocodone/APAP 5-325 mg revealed 22 tablets on the card. Interview with the DON on 8/29/16 at 11:37 AM, at the Nurse Station by medication cart #3 confirmed the narcotic records and the narcotic count for Resident #12 and #13 were incorrect. Continued interview with the DON confirmed the facility failed to accurately reconcile controlled medications.	F 431		
F 514	483.75(l)(1) RES	F 514		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514 SS=E	Continued From page 23 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to accurately document controlled medications on the Medication Administration Record (MAR) for 4 residents (#4, #5, #6, #7) residents of 10 residents reviewed. The findings included: Review of facility policy, Controlled Drug Accountability Procedure, dated 4/22/14 revealed, "...Each dose administered is to be signed out by the nurse on the controlled drug record and on the patient's eMAR (electronic medication administration record)..." Medical record review of a Controlled Drug Receipt/Record/Disposition Form for Resident #4 revealed Hydrocodone/APAP (narcotic pain medication) 10-325 mg (milligrams) tablets with	F 514	Requirement: The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete,accuarately documented, readily accessible; and systematically organized. The clinical record will contain sufficient information to identify the resident, a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screen conducted by the State; and progress notes. Corrective Action: 1. Registered Nurse #1 responsible for the documentation of the controlled medications for residents #4, #5, #6 and #7 on 6/30/16 and 7/1/16 has been terminated from the company and reported to the OIG and TN Board of Nursing. Registered Nurse #1 is no longer rehireable by this company. 2. 100% of all resident's Medication Administration records assigned to RN #1 were audited by the DON and Administrator immediately for any other incidents or discrepancies. 3. All licensed nurses will be re-educated by DON or designee on correct documentation and count process of narcotics, Schedule II drugs according to company policy and procedure by 11/4/2016. 4. DON or designee will randomly audit and compare resident's Narcotic Count/Control Sheets with Medication Administration Records 3 times a week for 2 weeks,2 times a week for 2 weeks, and 1 time a week for 2 weeks or until 100% compliance is acheived for 3 consecutive weeks.	11/4/16

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F 514	Continued From page 24 documentation 1 tablet signed out on 7/1/16 at 2:40 PM by RN #1. Continued review of the MAR for 7/1/16-7/25/16 revealed no documentation the Hydrocodone was administered to Resident #4 at 2:40 PM by RN #1. Medical record review of a Controlled Drug Receipt/Record/Disposition Form for Resident #5 revealed Oxycodone/APAP (narcotic pain medication) 7.5-325 mg tablets with documentation 1 tablet was signed out on 6/30/16 at 11:50 PM, and 1 tablet was signed out on 7/1/16 at 3:00 PM by RN #1. Continued review of the MAR for 6/30/16 revealed no documentation 1 tablet was administered to the resident at 11:50 PM. Continued review of the MAR for 7/1/16 revealed no documentation 1 tablet was administered to Resident #5 at 3:00 PM by RN #1. Medical record review of a Controlled Drug/Receipt/Record/Disposition Form for Resident #6 revealed Oxycodone/APAP 7.5-325 mg tablets with documentation 1 tablet signed out on 6/30/16 at 11:50 PM, and 1 tablet signed out on 7/1/16 at 3:00 PM by RN #1. Continued review of the MAR for 6/30/16 revealed no documentation 1 tablet was administered to the resident at 11:50 PM. Continued review of the MAR for 7/1/16 revealed no documentation 1 tablet was administered to Resident #6 at 3:00 PM by RN #1 Medical record review of a Controlled Drug/Receipt/Record/Disposition Form for Resident #6 revealed Oxycodone 15 mg tablets with documentation 1 tablet was signed out on 6/30/16 at 3:00 PM and another tablet signed out at 10:20 PM by RN #1. Continued review	F 514	Any findings will be addressed immediately with staff responsible per facility's policy by the Administrator. All results of the audits will be included in the facility's Quarterly QA/QI Meetings which are attended by all Facility Leadership and Medical Director. Per company policy, the findings will be reviewed for pertinent data, identify areas that may need additional attention, and determine specific goals to acheive if necessary. The facility Administrator will be responsible for overseeing the outcome of the findings and the QA/QI Process.	

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F 514	Continued From page 25 revealed 1 tablet was signed out on 7/1/16 at 3:00 PM by RN #1. Review of the MAR for 6/30/16 revealed no documentation the medication was administered to the resident at 3:00 PM or 10:20 PM. Continued review of the MAR for 7/1/16 revealed no documentation 1 tablet was administered to Resident #6 at 3:00 PM by RN #1. Medical record review of a Controlled Dug/Receipt/Record/Disposition Form for Resident #7 revealed Oxycodone IR 10 mg tablets with documentation 1 tablet signed out on 6/30/16 at 10:40 PM and 1 tablet signed out on 7/1/16 at 2:50 PM by RN #1. Review of the MAR for 6/30/16 revealed no documentation 1 tablet was administered to the resident at 10:40 PM. Continued review of the MAR for 7/1/16 revealed no documentation 1 tablet was administered to Resident #7 at 2:50 PM by RN #1. Interview with the Administrator in the Conference Room on 8/22/16 at 2:15 PM, confirmed the facility failed to accurately document administration of controlled medications for Resident's #4, #5, #6, and #7 on the Medication Administration Record.	F 514		